

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/07/2025
NAME OF PROVIDER OR SUPPLIER  Riverside Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  6801 E Riverside Dr Austin, TX 78741	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49099</p> <p>Based on observation, interview, and record review, the facility failed to provide safe, clean, comfortable, and homelike environment and to exercise reasonable care for the protection of the resident's property from loss or theft for 2 of 6 residents (Resident #1 and Resident #2) reviewed for personal belongings.</p> <p>1. The facility failed to ensure Resident #1 and Resident #2's clothes and belongings were reasonably protected from loss or theft.</p> <p>These failures placed residents at risk of diminished quality of life.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet revealed an [AGE] year-old male admitted to the facility 11/10/17 with diagnoses that included Alzheimer's disease with late onset (neurodegenerative disease), major depressive disorder-recurrent-moderate (mood disorder that causes persistent feelings of sadness and loss of interest), age-related physical debility, and adjustment disorder with anxiety (a condition where a person experiences significant anxiety symptoms within three months of a specific life change or stressor- can involve worry, nervousness, irritability and other anxiety related symptoms).</p> <p>Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS score of 3 indicating severe cognitive impairment.</p> <p>Record review of Resident #1's medical record revealed no inventory list.</p> <p>Record review of Resident #2's face sheet revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of upper outer quadrant of right female breast (cancerous tumor), systemic lupus erythematosus- unspecified (autoimmune disease that causes inflammation and damage in various organs and tissues), major depressive disorder-recurrent-moderate (mood disorder that causes persistent feelings of sadness and loss of interest), and generalized anxiety disorder (fear characterized by behavioral disturbances).</p> <p>Record review of Resident #2's quarterly MDS dated [DATE] revealed a BIMS score of 15 indicating cognition intact.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #2's medical record revealed no inventory list.</p> <p>In an interview on 01/07/25 at 02:11 PM with Resident #1, he stated he has noticed he had less clothes and said he thought some shirts were missing but had not personally reported any. Resident #1 was not sure if facility staff took an inventory of his items when he arrived at the facility.</p> <p>In an interview and observation on 01/07/25 at 02:26 PM with Resident #2, she stated laundry was always losing her clothes. She stated laundry is taking too long to wash her clothing and when she gets it back, she is missing clothes or gets back items that don't belong to her. Resident #2 stated she is missing multiple pairs of panties, socks, and nightgowns. Resident #2 stated she received a bag from laundry after staff claimed to have found her stuff, but that the items they gave her were not hers. Resident #2 was observed pulling out a clear plastic bag filled with clothes that had her name written on it. She stated the handwriting on the bag was not hers and was written by someone from housekeeping she was unable to identify. From the plastic bag Resident #2 pulled out multiple oversized shirts and she stated they were not hers, 2 sets of female panties, one which was observed to have a different resident's name on it written in black permanent marker, and a pair of men's boxer briefs. Resident #2 stated the facility did not take inventory of her items, and said she is frustrated and upset at her clothes going missing and being given clothes that are not hers.</p> <p>In an interview on 01/07/25 at 03:05 PM with the HS, she stated that lately it was common that clothing would arrive to the laundry room with no name on it. She stated that every Thursday they would try to set up an area in the dining room with clothing to ask residents if they recognized any of it as being theirs to claim it. She stated that recently in November 2024 she implemented an audit where she would check 1 person's room in each hall to see if they had clothing missing. She said it started November 20th 2024 due to a lot of clothing coming with no names. She stated it was the CNAs responsibility to write the residents' names on the clothes and that she was also beginning to train staff on the use of the label press but that not everyone was yet trained on it. She stated that the negative outcome of not having the residents' clothes easily identified has resulted in lost items and frustration from some residents.</p> <p>In an interview on 01/07/25 at 04:48 PM with Resident #1's family, he stated Resident #1 has had a lot of clothing go missing. He stated he wanted Resident #1 to have nice clothing and personally went out to purchase multiple polo style shirts for him in mid November 2024 and soon realized they went missing. Resident #1's family stated that he filed a complaint with the facility which has not been resolved and stated when he asked Resident #1 where the shirts went, he was unable to say. Resident #1's family stated that to his knowledge the facility did not inventory the residents clothing and claimed when speaking to the ADM that he stated it would be addressed but hasn't been. Resident #1s family claimed that in addition to the polo style shirts, he has also had personal blankets go missing.</p> <p>In an interview on 01/07/25 with the ADM, he stated it was his expectation that both nursing/ direct care staff as well as laundry staff manage the inventory and labeling of resident clothing and that all items should be labeled with the resident's name. The ADM stated that due to the issues with missing laundry they have implemented a weekly audit system where the HS was to audit resident closets from each hall to ensure their names were being written on their clothes. He stated a negative outcome of not labeling or taking inventory of resident items would be they could be lost, and residents would not get them back.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of grievances for the month of November 2024 revealed 5 reports revealing residents missing clothing, and review of grievances for the month of December 2024 revealed 6 reports of residents with missing clothing, which included a report of Resident #1 's missing shirts.</p> <p>Record review of the facility 2023 Resident Rights policy revealed:</p> <p>Respect and dignity- you have the right to be treated with respect and dignity including the right to:</p> <ul style="list-style-type: none"> <li>- Retain and use personal possessions including furnishings, and clothing as space permits unless to do so would infringe upon the rights or health and safety of other residents.</li> </ul> <p>You have the right to a safe, clean, comfortable and homelike environment and use of your personal belongings to the extent possible.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49099</p> <p>Based on observation, interview, and record review the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for kitchen and food sanitation.</p> <ol style="list-style-type: none"> <li>1. The facility failed to label, and date food stored in the walk-in refrigerator.</li> <li>2. The facility failed to label, and date food stored in the walk-in freezer.</li> <li>3. The facility failed to ensure food preparation areas and appliances, including equipment such as the fryer, microwave, toaster, blender, and ice machine were maintained clean and sanitary.</li> <li>4. The facility failed to ensure handwashing supplies were stocked at the kitchen handwashing station (no paper towels).</li> </ol> <p>These failures could place residents at risk for food contamination and foodborne illness.</p> <p>Findings included:</p> <p>During the initial tour of the kitchen on 01/07/25 at 10:30 AM the following was observed:</p> <ul style="list-style-type: none"> <li>- Upon entering and washing hands there were no paper towels observed stocked or in use at the handwashing station. A used rag from the food prep area was offered (and declined) by a dietary staff member to dry hands before the DM went out and returned to stock the handwashing station with paper towels.</li> <li>- In the walk-in refrigerator there was a plastic container of vegetable soup covered with plastic wrap with no label or dates as to when it was prepared and when it should be used by/ discarded. A separate plastic container containing chicken and pasta with a white sauce was observed not labeled or dated. A large clear container of tuna salad was observed not labeled or dated.</li> </ul> <p>In the walk-in freezer the following was observed:</p> <ul style="list-style-type: none"> <li>o 1 zip sealed bag containing breaded chicken filets not labeled or dated with the received date or use by date.</li> <li>o 1 zip seal bag containing raw chicken not labeled or dated with the received date or use by date.</li> <li>o 1 zip sealed bag containing raw beef burger patties not labeled or dated with the received date or use by date.</li> <li>o 1 approximately 10-pound clear tube of ground meat not labeled or dated with the received date or use by date.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>o 1 pie crust packed in a clear bag not labeled or dated with the received date or use by date.</p> <p>o 1 box containing tortilla wrapped taquitos not sealed, box was opened, and the contents exposed to open air.</p> <p>o 1 box containing a ripped bag of what appeared to be prepared omelets not labeled or dated with the received/ prepared date or use by date, not properly sealed and the contents exposed to open air.</p> <p>- The fryer was observed with a thick coat of dark grease surrounding the outside from all sides, and the inside door and bottom compartment below the temperature control. The fryer was not in use and uncovered.</p> <p>- The inside of the microwave was observed soiled in a yellow fluid on the round plate, and yellow/dark orange food splatters that appeared dry and stuck to the 3 inner walls, below the round rotating plate, and on the top 'ceiling' of the microwave. The microwave door was also observed covered in the dried yellow/dark orange, dried, stuck on substances.</p> <p>- The blender had a yellow-green residue stuck to the top element where the container sat on; it appeared dried and ran down to where the sides and buttons were located.</p> <p>- The toaster oven had a thick layer of oil residue and crumbs.</p> <p>- The inside of the ice machine was observed to be soiled. On the top plastic inner wall behind the lid just above the ice there was a slimy pink/yellow residue with smaller dark spots of an unknown substance that ran the entire length of the inner plastic above the ice. The inner back side of the lid was observed with a white powdery-like substance.</p> <p>- The kitchen floors were observed completely soiled. A puddle of a red juice and other dark fluids were observed in front of the drink machine which was also observed soiled in red stained and dark stained fluids. The floors in the food preparation area under the steamtable and 2 compartment sinks to the right of the steamtable were observed with sections of a dark black residue, there were cereal containers, plastic lids, packets of condiments and butter, and food that soiled the floors beneath the two areas.</p> <p>In an interview on 01/07/25 at 10:50 AM with the DM, he stated it was his expectation that all food items were labeled and dated with either the received or prepared date and the use by date when items are placed into the refrigerator/freezer. He stated it was his expectation that food items were always properly sealed in either a sealed container, zip seal bag, or if in a box sealed/closed and the food not exposed. He stated it was his expectation that dietary staff maintained a clean environment and said items not properly labeled or dated or an environment that was not clean could potentially result in residents getting sick. The DM stated he expected the necessary supplies to be stocked in order to follow hand hygiene guidelines. He stated it is the responsibility of anyone who notices that the paper towels are empty should replace them.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 01/07/25 at 5:45 PM with the ADM, he stated Food should be stored according to the regulation, and it needs to be followed. He stated it was his expectation that items were labeled/dated and sealed when stored in the refrigerator/freezer and if they were not sealed or closed off it could result in cross contamination or food spoilage. The ADM stated that cleaning should be done on an as needed basis and that if dietary staff see that items are soiled in between mealtimes, they should be cleaned. He stated failure to maintain a clean environment could result in cross contamination and spreading of germs.</p> <p>Record review of the facility Infection Prevention and Control Program last revised 10/2022 revealed:</p> <p>The infection prevention and control program is a facility- wide effort involving all disciplines and individuals as is an integral part of the quality assurance and performance improvement plan .it is the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene based on accepted standards.</p> <ul style="list-style-type: none"> <li>- The facility will provide areas, equipment, and supplies to implement its infection control program with the goal of: <ul style="list-style-type: none"> <li>o Readily available of hand cleaning supplies and paper towels at each sink.</li> </ul> </li> </ul> <p>Record review of Dietary Services Meals and Food policy dated 06/2017 revealed:</p> <p>It is the policy of this facility to ensure dietary services are provided to our residents operating within the confines of Texas state regulations.</p> <ul style="list-style-type: none"> <li>- A dietary manager is responsible for the total food service of this facility.</li> <li>- Food purchased, stored, and serviced in this facility is labeled and dated according to all applicable food service regulations.</li> <li>- Food prepared for consumption by our residents is prepared according to all applicable food service regulations.</li> </ul> <p>Record review of Resident/ Personal Food Storage policy dated 06/2017 revealed:</p> <ul style="list-style-type: none"> <li>- Food storage areas shall be clean at all times.</li> <li>- All food stored in facility refrigerator will be labeled and discarded after being opened for three days.</li> </ul> <p>Review of the 2022 U.S. Food and Drug Administration Food Code revealed:</p> <p>3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>(A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.</p> <p>(B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: P if</p> <p>(1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; Of and</p> <p>(2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety.</p> <p>3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition.</p> <p>(A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it:</p> <p>(2) Is in a container or PACKAGE that does not bear a date or day; or</p> <p>3-302.11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation.</p> <p>FOOD shall be protected from cross contamination by:</p> <p>(4) Except as specified under Subparagraph 3-501.15(B)(2) and in (B) of this section, storing the food in packages, covered containers, or wrappings.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>49099</p> <p>Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the transmission of communicable diseases and infections for 1 of 1 laundry facility reviewed for infection control.</p> <p>1. The facility failed to ensure LS A was following handwashing and sanitation when working with soiled clothing and moving to clean clothing; and failing to keep items stocked and readily available for use in hand hygiene (paper towels).</p> <p>2. The facility failed to ensure laundry staff was maintaining and cleaning the lint traps for both commercial sized tumble dryers in the clean laundry room side.</p> <p>This failure could place residents at risk for development of communicable diseases and infections.</p> <p>Findings include:</p> <p>During a tour of the laundry room on 01/07/25 at 02:50 PM the following was observed:</p> <p>- LS A was observed to be the only staff working in the laundry room at the time. She was observed working with soiled linen in the dirty or soiled linen side of the laundry area. LS A was observed rinsing her hands at the handwash station located on the wall across from the washing machines in the soiled linen side, and no soap was observed to be used. LS A was then observed moving to the clean room side as her hands dripped with water from not drying her hands, then grabbing the hand sanitizer, applying it to her dripping hands and then shaking her hands to dry. The paper towel dispenser at the handwashing station was observed empty .</p> <p>- The lint traps were checked on the commercial size tumble dryers which were observed with thick layers of lint. The lint cleaning log which was hanging on a wall near the dryers was reviewed and there was no documentation showing the lint trap was cleaned for any day in the month of January 2025.</p> <p>In an interview and observation on 01/07/25 at 03:05 PM with the HS, she stated it was her expectation that the lint traps were cleaned every time after the dryer has been used. She stated that laundry staff should also be logging each time it was cleaned on the log. The HS stated that failure to clean the lint traps posed a fire hazard and can be unsanitary. The HS was observed speaking to LS A providing education on cleaning the lint traps and LS A was observed asking questions about the cleaning log indicating that she was not aware of it and did not know how to complete it. The HS also stated that she expected that staff were washing their hands with soap and water before moving to the clean linen and completely drying their hands. She stated paper towels should be stocked and available. The HS stated that she personally provides training on the procedures and reminds staff that a negative outcome of not washing their hands would be possible contamination of cleaning clothing.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 01/07/25 at 04:20 PM with LS A, she stated that when working with soiled linen she should have been wearing gloves and washing her hands before moving to the clean linen. LS A stated that she was in-serviced that day on cleaning the lint traps on the dryers and stated that they should be cleaned after each cycle . LS A stated a negative outcome of not cleaning the lint traps was it is a fire hazard and can hold on to bacteria and stated failing to follow handwashing and sanitation could result in contamination of clean clothing. LS A stated she had been working at the facility for a month and was still learning the rules.</p> <p>In an interview on 01/07/25 at 05:45 PM with the ADM, he stated that handling linen in some instances would require the use of gloves, but that it was his expectation that staff were always washing their hands before moving to clean laundry after working with soiled linen. He stated it was his expectation that the handwash station remained stocked with the necessities such as soap, water, and paper towels in order to follow proper handwashing procedures. The ADM stated the lint traps should be cleaned as needed for the machines to be safe. He stated failure to keep the lint traps clean could result in improper function of the dryer.</p> <p>Record review of the facility Wellness Services Laundry Services policy dated 06/2017 revealed:</p> <p>It is the policy of this facility to ensure resident laundry is washed, dried, folded, or hung up by care staff in a way to prevent infection control issues.</p> <ul style="list-style-type: none"> <li>- Staff will empty the lint trap in each dryer as needed.</li> </ul> <p>Record review of the facility Infection Prevention and Control Program last revised 10/2022 revealed:</p> <p>The infection prevention and control program is a facility- wide effort involving all disciplines and individuals as is an integral part of the quality assurance and performance improvement plan .it is the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene based on accepted standards.</p> <ul style="list-style-type: none"> <li>- Facility personnel will handle, store, process, and transport linens so as to prevent the spread of infection.</li> <li>- The facility will provide areas, equipment, and supplies to implement its infection control program with the goal of: <ul style="list-style-type: none"> <li>o Readily available of hand cleaning supplies and paper towels at each sink.</li> </ul> </li> </ul>		